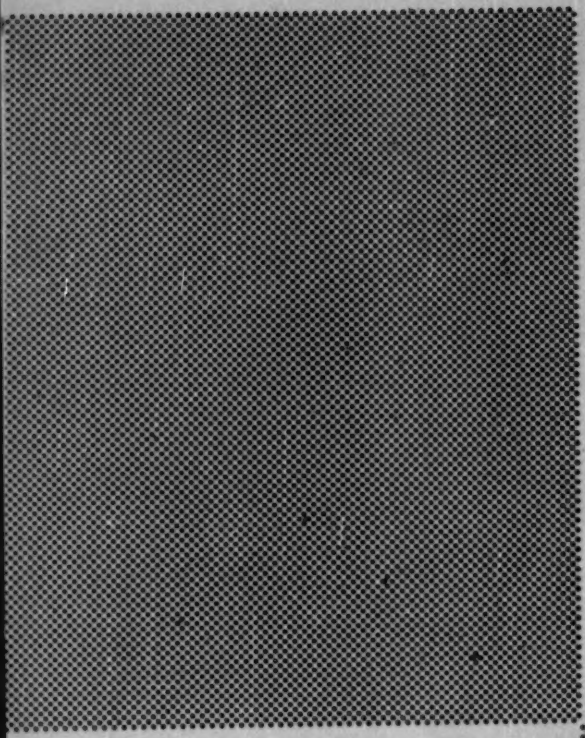
JOURNAL OF SOCIAL HYGIENE



VOL. 36 NOVEMBER 1950 NO. 8

IN THIS ISSUE

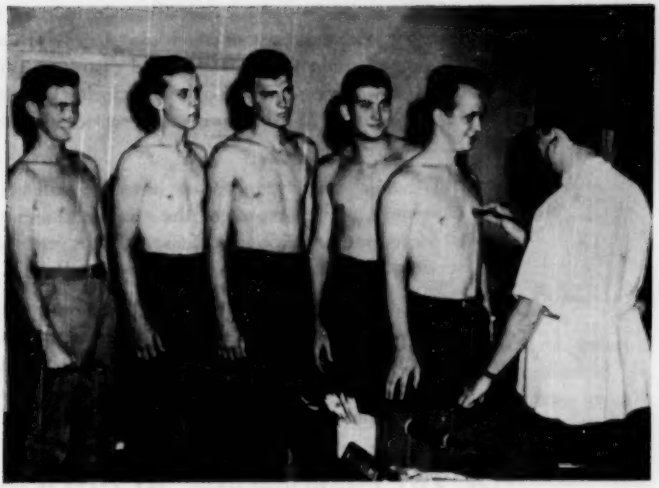
NOVEMBER 1950

Eleanor Shenehon, Acting Editor

THE JOURNAL OF SOCIAL HYGIENE

official periodical of the American Social Hygiene Association published monthly except July, August and September at the Boyd Printing Company, Inc., 374 Broadway, Albany 7, N. Y. Acceptance for mailing at the special rate of postage provided for in Section 1103, Act of October 3, 1917. Entered as second-class matter at the Post Office at Albany, N. Y., March 23, 1922.

The JOURNAL does not necessarily endorse or assume responsibility for opinions expressed in articles, nor does the reviewing of a book imply its recommendation by the American Social Hygiene Association.



V. I. P.'S

(In September, Community Chests and Councils of America sent this editorial, in a cooperative publicity kit on emergency services for the Armed Forces, to all Chests of the country.)

The Very Important Persons of America today are the young men in the Armed Forces. Our whole future depends on their morale and well-being. They must be able and ready to protect us. That is their job.

What is our job? What is our responsibility to them? At the very least, our duty to them is three-fold.

★ We must provide suitable places where they can relax when off duty, write letters home, make new friends and in a variety of ways feel wanted and appreciated by the civilian community. The Associated Services for the Armed Forces represent the American people in providing these hospitality services.

★ We must provide emergency services for the military personnel and civilians moving about the country in the cause of national security. The National Travelers Aid Association is prepared to make available information on housing, churches, eating-places, employment and travel, and to supply emergency loans for servicemen and helpful services for their families.

★ And we must protect servicemen from prostitutes, brothel-keepers and unscrupulous tavern-owners who quickly move into "easy-money towns" to take advantage of the inexperienced and homesick. It is

part of our job to prevent degrading, devitalizing sexual promiscuity (and the venereal diseases which too often follow sexual misconduct) by strengthening the education and character-guidance activities of the Armed Forces. The American Social Hygiene Association can act for all of us in protecting young servicemen from the prostitution racket.

Together these organizations have the skill and experience to do these jobs. They represent the civilian community and its desire to do its part in national defense. Their very existence assures the serviceman that he is a Very Important Person.

But their existence depends on the amount of money made available to them to help the men in the Armed Forces. That amount will be as great as the nation's patriotism and love of liberty. It will be as generous as America's gratitude to her men in uniform. It will be as unselfish as their sacrifice for us all.

THE ART OF PURSUING IN COMMON

In 1831–32 a young French aristocrat, Alexis de Tocqueville, traveled from his homeland to America to observe and study the customs and institutions of the new democracy across the Atlantic. The United States was less than fifty years old at the time of his visit, but life here, molded by the concepts of the founding fathers as expressed in our Constitution, had already begun to assume the shape that it still holds today.

The following quotation from de Tocqueville's *Democracy in America* gives a vivid early picture of the working of our national genius for organization as expressed in the banding together of private citizens to attain some desired end, large or small. It will sound very familiar to today's Americans, accustomed as they are to accepting responsibility for the public welfare and to acting together.

"Americans of all ages, all conditions, and all dispositions, constantly form associations. They have not only commercial and manufacturing companies, in which all take part, but associations of a thousand other kinds—religious, moral, serious, futile, extensive or restricted, enormous or diminutive. The Americans make associations to give entertainments, to found establishments for education, to build inns, to construct churches, to diffuse books, to send missionaries to the antipodes; and in this manner they found hospitals, prisons, and schools. If it be proposed to advance some truth, or to foster some feeling by the encouragement of a great example, they form a society. Wherever, at the head of some new undertaking, you see the Government in France, or a man of rank in England, in the United States you will be sure to find an association.

"If it be proposed to advance some truth . . ."

I met with several kinds of associations in America, of which I confess I had no previous notion; and I have often admired the extreme skill with which the inhabitants of the United States succeed in proposing a common object to the exertions of a great many men, and in getting them voluntarily to pursue it. . . . The English often perform great things singly; whereas the Americans form associations for the smallest undertakings. It is evident that the former people consider association as a powerful means of action, but the latter seem to regard it as the only means they have of acting.

"Thus the most democratic country on the face of the earth is that in which men have in our time carried to the highest perfection the art of pursuing in common the object of their common desires, and have applied this new science to the greatest number of purposes. Is this the result of accident? or is there in reality any necessary connection between the principle of association and that of equality? Aristocratic communities always contain, among a multitude of persons who by themselves are powerless, a small number of powerful and wealthy citizens, each of whom can achieve great undertakings single-handed. In aristocratic societies men do not need to combine in order to act, because they are strongly held together. Every wealthy and powerful citizen constitutes the head of a permanent and compulsory association, composed of all those who are dependent upon him, or whom he makes subservient to the execution of his designs. Among democratic nations, on the contrary, all the citizens are independent and feeble; they can do hardly anything by themselves, and none of them can oblige his fellow-men to lend him their assistance. They all, therefore, fall into a state of incapacity, if they do not learn voluntarily to help each other. If men living in democratic countries had no right and no inclination to associate for political purposes, their independence would be in great jeopardy; but they might long preserve their wealth and their cultivation: whereas if they never acquired the habit of forming associations in ordinary life, civilization itself would be endangered."

PARTNERS

How Social Hygiene Works with You in Your Community to Build Healthy Personal and Family Life

Do you realize how much unseen effort goes into the making of a good community? Into the kind of place where you want to make your home, rear your children and help them build their future?

Take your school. Some of the effort there is direct. You can see it in the board, superintendent and principal, the teachers and PTA, the children themselves, the buildings, books and laboratory equipment.

But much is indirect. Researchers find new and better methods of teaching. Authors and publishers supply textbooks. Legislatures write education laws. Colleges train teachers. Taxpayers pay the bill for good education.

Or take your telephone. Forty years ago you walked to the wall, wound a crank and said, "Hello, Gertrude. Give me Dorsey's store." Today we take for granted the research laboratories which give us dial phones, long distance connections, highly trained operators, phones in cars, trains and ships, and inventions yet to come.

Like the buried cables of your telephone, like the indirect influence of the textbook publisher, the services of the American Social Hygiene Association may or may not be seen, but they are not any the less necessary and valuable to your health and future welfare. They make for a better social and health situation in your town. They help you build a better community, a better place for your children to grow up in.

The value of social hygiene becomes simple and clear when you think merely about

- The treatment of VD
- The difference in attitude of the newspapers and other avenues of public information
- The difference in attitude of public officials
- The ways in which mothers and fathers can now get the modern scientific help they need to guide young people toward successful marriage, parenthood and happy family life.

In each of these, the American Social Hygiene Association has played and now plays a decisive role.

But the change from the bad old days has been so gradual, the effort so well integrated and astutely timed, that few realize the extent of social hygiene's singular influence in their lives.

Take the elementary question of VD treatment.

A generation ago most reputable doctors would have nothing to do with VD. A VD patient had to resort to quacks or to a drugstore clerk who would step around the counter to slip him a worthless salve.

Over the years, as the American Social Hygiene Association worked with the American Medical Association, American Pharmaceutical Association and public health officials, a great change occurred. VD quacks have gone out of business. Druggists no longer treat syphilis and gonorrhea. The change has been quiet, complete.

Or take your newspaper. Forty years ago—before ASHA—no newspaper would print the words "syphilis" and "gonorrhea." The American Social Hygiene Association led the effort to convince editors that they should help bring VD out into the open so that science could attack it with frank vigor. Now newspapers are our firm allies in the fight for effective VD control.

The press isn't the only medium which helps to do the educational job. School superintendents call on the American Social Hygiene Association to help them train teachers and plan courses which give children the understanding of themselves which strengthens family life and prevents unhappiness.

Thousands of parents now order pamphlets and books on sex education and family life directly from the American Social Hygiene Association. Many others obtain social hygiene publications indirectly through other national organizations with whom ASHA maintains close cooperation—the PTA, Federal Council of Churches, National Sheriffs Association, YWCA and many others.

The American Social Hygiene Association energetically supports every city in the country in suppressing vice and ridding our land of prostitution racketeers. For over 30 years ASHA's field workers have studied prostitution wherever it exists in the United States and have helped appropriate civil and military officials and leading citizens to repress sexual vice.

With ASHA's help, many cities have closed their red-light districts and have worked hard to maintain a wholesome environment for young people. Some made great progress in wiping out prostitution

during the war, when, as now, the health and well-being of millions of men, away from home and family ties, depended upon protection from degrading sex experiences and VD.

In times of national crisis, the military relies heavily on the American Social Hygiene Association to keep communities adjacent to military areas clean and to provide suitable educational and inspirational publications for men in the Armed Forces.

When you consider the youth of our servicemen and the loneliness of their lives in such all-important outposts as Alaska, you can see that the American Social Hygiene Association's help is essential in the present national defense picture.

ASHA's work is unique in preventing prostitutes and their pimps from sabotaging defense by spreading VD and by undermining the morals of the men whose job is to defend our country. Equally, social hygiene helps protect the young people of civilian communities from the prostitution racketeer.

In many other ways—through training courses for teachers, health officers and social hygiene workers; through the preemployment blood tests many industries require; through books and pamphlets on sex education that are in your home and public library; through preparation-for-marriage lectures sponsored by your Y or Ministerial Association; through helpful articles on sex which appear in popular magazines; through laws requiring marriage license applicants and expectant mothers to have blood tests—in these and other ways social hygiene works with you and your community to build healthy personal and family life.

These are social hygiene's goals:

- Strong, healthy family life in America
- Education for successful marriage and parenthood
- Community services which help families to hold together
- Laws which protect families and young people
- Wholesome communities, free of prostitution and quackery
- Freedom from the menace of venereal disease

This is what the American Social Hygiene Association works for, directly and indirectly, visibly and invisibly.

With your help, we can reach these goals together, for ourselves, for our children.

ARE VENEREAL DISEASES DISAPPEARING?

Over-All Picture Throughout the Country

by W. H. Aufranc, Medical Director, Assistant Chief, Division of Venereal Disease, United States Public Health Service

(Excerpts from a speech before the New York Tuberculosis and Health Association March 7, 1950.)

Today, when we talk about the venereal diseases, we speak principally of syphilis. Gonorrhea control is still considered a public health function, but the simplicity of modern therapy and the readiness with which infected persons seek treatment for this disease—thus avoiding its most serious complications—tend to place it in a different category from syphilis. Therefore, it is syphilis to which my remarks principally apply.

Although our records are not complete in many respects, they do, we believe, reflect a reduction in the syphilis problem during the 11 years of federally aided VD control. During this period we have noted the following gains:

- In 1949, infant mortality from syphilis was about one-fifth the rate for 1938.
- Syphilis mortality has been reduced 48 percent.
- Admissions to mental institutions because of syphilis have been reduced 34 percent.
- The reported attack rate of syphilis has decreased consistently for the last three and one-half years.

We believe that these gains are in some measure the result of three major achievements of the past few years: improved case-finding technics, improved diagnostic aids and, last but not least, the widespread use of penicillin in the treatment of syphilis.

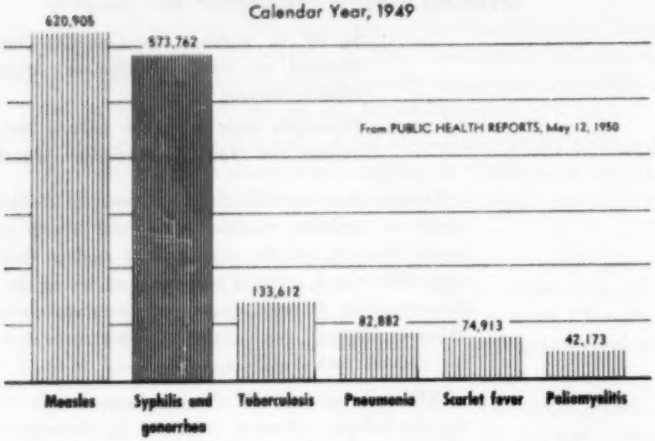
Some of our colleagues in the public health field believe that, because we now have penicillin, the syphilis problem in the United States will gradually decline, without any special public health effort. One flaw in this view is that syphilis is not a disease which prompts people to seek treatment voluntarily. Moreover, there are thickly settled rural areas of the United States where the incidence of syphilis is high and physicians and medical care facilities are few. In these areas, case-finding and other services made available through a venereal disease control program are clearly needed.

Many public health officials believe that we should embark upon an intensive program of syphilis control, aimed at eradication of the disease. If treatment schedules now under evaluation, consisting of 1, 2 or 3 penicillin injections, should prove effective, it would

Reported Cases of Selected Communicable Diseases

in the Continental United States

Calendar Year, 1949



seem that some kind of an eradication program should be considered. Such a program, instituted on a wide scale, would be costly. It could have the result, however, of reducing the syphilis problem to a small number of smoldering cases controllable by means of a few basic public health services. An eradication program might, therefore, be the most practical course to pursue.

Lest these comments suggest that venereal disease has already disappeared in the United States, let me hasten to add that syphilis must still be considered a major public health problem, because in 1949:

- It infected 150,000 persons, 80,000 of whom were undiscovered.
- It sent 6,000 persons to mental institutions.
- Its causative organism entered the blood stream, before birth, of 14,000 innocent children.
- It killed 13,000 people.
- An estimated 3,000,000 persons in the United States would have had positive reactions, if the entire population of the United States had been blood-tested.

It is our belief that if judicious expenditure of funds, effective use of trained personnel, and careful employment of facilities are continued, syphilis will eventually be controlled to the same extent as smallpox, typhoid fever and diphtheria. But in the face of a problem so massive as that of syphilis today, it seems too bold to predict that venereal diseases will disappear or even to contend that they are disappearing. It can only be said with certainty that they have not yet disappeared.

WHO KNOWS WHAT ABOUT VD?

Results of an Exploratory Study

by John A. Morsell, Director, Sydenham Institute of Community Relations, Sydenham Hospital, and Rose K. Goldsen, Research Associate, Bureau of Applied Social Research, Columbia University

(The research on which this study is based was performed jointly by the Sydenham Institute of Community Relations and the Bureau of Applied Social Research of Columbia University, with the aid of the Division of Venereal Disease of the United States Public Health Service.)

Exactly how much emphasis should be placed upon the spread of factual information in devising venereal disease control programs is still an unanswered question; much, it must be supposed, as is the case in other fields of public health. Whether it is held that, once in possession of the facts, people will automatically follow a desired course, or whether the facts are conceived of as merely the minimum of information upon which any appeal must be based, a knowledge of the extent to which the facts are known is of obvious importance.

The present paper examines a recent survey of knowledge and opinion of venereal disease for what it discloses or implies regarding the state of popular knowledge of VD, how people differ in what they know about it, what kinds of people know more than others, how the knowledge was acquired, and what all of this suggests for evaluating the role of information.

The data reported here were obtained from 254 interviews with a sample of the general population of the upper west side of Manhattan during the spring of 1948. Although this population, like that of the city as a whole, is varied economically and in ethnic background and religious affiliation, the sample is not claimed to be adequate as to either size or representativeness.[1]

[1] The sample was drawn from an area with a 1940 population of 99,261, 47.4 percent were males, 47.2 percent were under 35 years of age, 3.1 percent were Negroes, and 53.3 percent had completed over eight years of schooling. The sample composition is fairly similar except in the case of education, where the discrepancy remains large even when determined for comparable age groups. Forty-seven percent of the sample were males, 53 percent were under 35 years, 12 percent were Negroes, and 78 percent had had more than eight years' schooling. No reliable data were available as to the area's religious composition, but the sample included 28 percent Protestants, 43 percent Catholics and 21 percent Jews. There was, likewise, no way of knowing to what extent the 1940 census figures were still representative at the time of the survey.

The immediate object of the study was to serve as a proving-ground for the utility and adequacy of questionnaire items dealing with VD, and, as such, it was one of the important preliminaries in the planning of studies in Columbus, Ohio, by the Bureau of Applied Social Research of Columbia University, and in Mississippi by Robert O. Carlson, both in cooperation with the United States Public Health Service.

While it is thus seen that the data were not expected to yield conclusive results—and probably raise more questions than they answer—their analysis has nevertheless produced suggestive findings which were of value in directing these further inquiries.

I. Information Levels

The 254 respondents were classified on three levels of knowledge about VD, in terms of an Index of Information constructed from their responses to four information questions. The first group—the Well-Informed—included all those who made correct responses to all four questions; the second group—the Moderately-Informed—consisted of those answering three questions correctly; and the third—the Least-Informed—included all who were right on fewer than three questions.

It was not feasible to weight the questions as to their importance as determined by some objective criterion, and this desirable refinement is therefore lacking.

Following are the questions which were used, the basis for determining right and wrong responses,[2] and the percentages of right and wrong answers occurring in the sample as a whole.

Division of the sample according to respondents' standing on the Information Index found them distributed in these proportions:

	Percent	Number
Well-Informed	34	(86)
Mod.-Informed	41	(104)
Least-Informed	25	(64)
	100	(254)

We should expect that these proportions would vary when we are dealing with the various population groups represented in the sample. This variation in terms of differences in sex, age, education and the like is described in the next section.

[2] "Right" and "wrong" are not intended, of course, to refer to the correctness or incorrectness of answers according to criteria of strict medical accuracy. They are judgments based on the agreement of responses with the body of VD fact as it is presented in the popular VD educational literature, and on the capacity of the answers to differentiate respondents in these terms.

The Index of Information

Question	Definition of right and wrong answer	Percent In Sample Right	Wrong
A. What troubles or symptoms do people have when they first get syphilis?	A "Don't Know" (DK) reponse was treated, for this purpose, as a wrong answer. Over 4/5 of the wrong answers are DK; the rest are clearly incorrect as statements of the initial signs of syphilis (e.g., blindness, paralysis, etc.)	55%	45%
B. Could a druggist do anything for (person who suspects he has syphilis)?	"Don't Know" answers, including uncertainty ("perhaps", "might help", etc.) make up slightly over half the responses classified as wrong; the remainder are those stating that the druggist can be helpful *on his own initiative*.	82%	18%
C. Do you think it is possible to get really cured of syphilis?	Wrong answers here were defined as: "Don't Know"; "No"; and chances either "Good" or "Poor" without any qualifying statement (as to how soon treatment is obtained).	67%	33%
D. What will happen to a person who has syphilis if he never gets treatment for it?	"Don't Know" answers are almost 90% of those here classified as wrong; the balance are those few clearly in error (e.g., "he will get tuberculosis", etc.)	75%	25%

In about one-fifth of the cases, Question A was not asked, and the following was accordingly substituted for it:

E. Are there any differences between syphilis and gonorrhea? What are they?	About three-fifths of the wrong answers here were "Don't Know"; the remainder included those denying any difference, those not knowing what the differences are, and those saying one disease is a stage of the other.	56%	44%

II. Information and the People Who Have It

Information Level and Sex

When the amounts of VD information possessed by men and women are compared, the results are as shown in the adjoining table. Although the differences are in the direction of a somewhat higher level of information among men than among women, they are not large enough to document the assumption of a sex difference in knowledge of VD.[3]

Sex	Men	Women
	%	%
Well-Informed	36	32
Mod.-Informed	43	39
Least-Informed	21	29
Total Cases (=100%)	(119)	(135)

Information Level and Education

A close connection between the amount of formal education reported by respondents and the level of information they possess about venereal disease is apparent here. Higher educational attainment is positively correlated with amount of information, in a table that is unusually symmetrical for the sample size.

Education *	None or Grammar	High School	College
	%	%	%
Well-Informed	21	34	43
Mod.-Informed	41	42	40
Least-Informed	38	24	17
Total Cases (=100%)	(56)	(128)	(70)

[3] The chances that differences among percentages in this and the succeeding tables are attributable to sampling error have been determined by application of the Chi-square test. Most of the tables do not meet the requirements for significance at the .05 level. Where significance does exist, it has been indicated by either a single (.05 level) or a double (.01 level) asterisk. Strictly speaking, it is not correct to apply these tests to samples which do not also satisfy the requirement that they be random. It would be more accurate, therefore, to say that these would be the findings as to significance, in samples of this size, *if* the samples were also random (i.e., statistically representative of the universe from which they are taken). The general consistency of pattern, even where significance is not statistically demonstrable, is apparent in the summary table at the end of this section.

Information Level and Age

For greater convenience and reliability in a sample of such small size, age of respondents was classified as either young (under 35 years) or old (35 years and over). Here the differences are again clearly defined, the younger respondents being distinctly better informed about venereal disease than are the older respondents. Since, as we have seen, education is correlated with information level, this is in accord with expectation based upon the known educational differences between older and younger people.

Age *

	Under 35 %	35 and over %
Well-Informed	39	28
Mod.-Informed	42	40
Least-Informed	19	32
Total Cases (=100%)	(133)	(121)

Information Level and Knowledge of Related Matters

A high level of information about venereal disease is similarly associated with greater knowledge of other, more or less related, items. Well-informed respondents, for example, were more likely than others to be aware of the practice, in venereal disease treatment centers, of making contact inquiries and investigations—and to understand the reasons for these procedures. (It may be added that the great preponderance of respondents expressed themselves as approving contact investigation.)

Contact Inquiry

	Aware %	Unaware %
Well-Informed	39	30
Mod.-Informed	43	39
Least-Informed	18	31
Total Cases (=100%)	(102)	(148)

Level of information is found to have a similar relationship to replies to the question: "Have you heard of the Kinsey Report? (If YES) What is it?" Once again, Well-Informed and Least-Informed respondents are at the extremes of awareness and ignorance of this highly-publicized study.

Kinsey Report *

	Familiar	Unfamiliar
	%	%
Well-Informed	43	28
Mod.-Informed	42	41
Least-Informed	15	31
Total Cases (=100%)	(98)	(155)

Information Level and Military Service

Because of changes made in the schedule in the course of the survey, veteran status was not ascertained for all respondents. For those for whom it is known, however, it is clear that military experience—or, more exactly, the relevant components of the military experience—succeeded in imparting a degree of knowledge about venereal disease somewhat greater than might ordinarily be attributable either to the lower age level of veterans in general (since young respondents were better-informed than old), or to the greater education they may be presumed, on that account, to have had (since young people are better-educated than old, and education was found to correlate with information level).

Veteran * Status

	Veterans	Non-Veterans
	%	%
Well-Informed	45	26
Mod.-Informed	40	46
Least-Informed	15	28
Total Cases (=100%)	(58)	(133) [4]

Of all the factors so far considered, whether or not respondent was a veteran appears to produce the greatest margin of difference in where he is classified with respect to level of information about VD.

Information Level and Socio-Economic Status

Socio-economic status was rated intuitively from high to low on an arbitrary A, B, C, D scale. In these tabulations, the A and B groups have been combined. Since it is known that socio-economic status is normally closely correlated with educational attainment,

[4] Although an earlier table suggested no apparent sex difference, it may be of interest to know the sex distribution by veteran status: All but two of the veterans were men; not quite three-fourths of the non-veterans (in this table) were women.

there is incidental corroborative value for the SES ratings in the fact that they bear about the same relationship to information level as does education. High socio-economic status is likewise positively correlated with amount of information about VD.

Socio-Economic Status	AB	C	D
	%	%	%
Well-Informed	44	35	27
Mod.-Informed	37	38	46
Least-Informed	19	27	27
Total Cases (=100%)	(52)	(115)	(87)

Information Level and Socio-Economic Status, Age Controlled

Both socio-economic status and age maintain, in combination, the relationships they were just seen to hold independently. Thus, while younger respondents ranked higher in information than older ones on every socio-economic level, those on lower levels were found to be much less well-informed than those on higher levels. There is added point to this finding when it is realized that most of those under 35 years of age at the time of the interview had completed their formal education within the last fifteen years, during which popular concern with venereal disease and the spread of information about it were on a previously unexperienced scale.

Proportions of Young and Old Respondents from Different Socio-Economic Classes on the Three Information Levels

	AB		*C*		*D*	
	Young	Old	Young	Old	Young	Old
	%	%	%	%	%	%
Well-Informed	56	39	42	26	32	17
Mod.-Informed	44	33	37	41	47	47
Least-Informed	—	28	21	33	21	36
Total Cases (=100%)	(16)	(36)	(60)	(54)	(57)	(30)

This evidence that, despite the greater access to educational facilities which we assume exists for the young of all groups, there yet persist socio-economic differentials in the extent to which younger persons are informed about VD, leads naturally to examination of the manner in which such information was originally acquired. It is important to know how the well-informed differed from the others, if they did, in respect to the way in which they got their first knowledge of VD: i.e., the age at which they were introduced to the subject and the sources of their introductions.

Information Level and How First Learned of VD

For respondents able to recall the age at which they first heard about VD (93% of the total made this claim), there is a clear showing that the better-informed were the ones who received earlier introductions to the subject.[5] Nearly half of those who said they first heard about VD before they were 15 years old were found to be in the Well-Informed category, as against not quite a third of those whose introductions came later. Only 16% of the early learners (those under 15) fell into the Least-Informed category, in contrast to 24% of those who learned at age 15 or older, and to 36% of those who had reached the age of 25 before their introductions.

Age At Which First Learned of VD

	Under 15 %	15 and over %	25 and over %
Well-Informed	46	32	32
Mod.-Informed	38	44	32
Least-Informed	16	24	36
Total Cases (=100%)	(66)	(168)	(19)

Almost 90% of the respondents said that they remembered how they felt at the time they were first made acquainted with the existence of venereal diseases; 51% reported that this original feeling had changed in the meantime; and 43% attributed the changed feelings to their *knowing more* now than they did then. There are differences by Information Level in the proportions reporting changed feelings; the differences are even more marked when the change is ascribed to more knowledge.

Compared with Feeling When First Learned of VD

	Feel Different Now (Unqualified) %	Total Cases (=100%)	Feel Different Now (Because Know More) %	Total Cases (=100%)
Well-Informed	59	(86)	52	(86)
Mod.-Informed	54	(104)	43	(104)
Least-Informed	36	(64)	30	(64)

[5] Alternatively, of course, these data may plausibly be interpreted as meaning that persons who are better-informed about VD (for whatever reason) are more likely to recall—or to think they recall—the circumstances of their introduction to the subject.

Whether, or to what extent, the age of introduction to VD knowledge is of significance, in itself, cannot be illuminated by our data. What it implies as to the *source* of the introduction, however, can be explored. An acceptable hypothesis would make certain assumptions, for example, about the cultural and economic level of homes in which children are given early information about sex and related matters; it would also infer that the information source would be of the kind commonly regarded as most acceptable: especially, a parent or a teacher.

There are, in fact, differences in these respects among respondents on different information levels:

Source of First Information

	School or Parent %	Other Personal %	Literature, Other Impersonal %
Well-Informed	41	34	24
Mod.-Informed	41	39	43
Least-Informed	18	27	33
Total Cases (=100%)	(58)	(125)	(54)

The group which reports school or parents as the source of early VD information includes more who are well-informed than does either of the other groups. Proportions on the different information levels are about the same for those reporting introductions through other persons, such as friends, relatives and acquaintances; and more of the Least- and Moderately-Informed are found among those who reported literature, posters and other impersonal media.

The data are not sufficiently explicit as to the nature of these formal media to reveal why this difference should occur in their case; it is suggested, however, that the correlating element is the casual, unguided selection and interpretation of such material by most of those who obtained their introduction thereby.

Perhaps the most important intimation to be derived from these data on the time and circumstances of respondents' introductions to VD is the evident failure of so many to have their introduction early enough for it to have the preferred character and effect. If it is desirable that knowledge of VD be rooted in early instruction under controlled and responsible auspices, then either the home or the school is the indicated agency.

But we know that a large segment of the population is subject to a combination of cultural and economic conditions in which, on the one hand, it is least likely that parents will have such discussions with their children; and, on the other, it is least likely that the children will remain at school long enough to encounter such modest references to the subject as are generally permitted in the curriculum.

Information Level and Source of Most Information

As a final element in the context of acquisition of VD knowledge, respondents were asked where they learned *most* of what they knew about venereal diseases. The results are in accord with what we should expect from the manner of their introduction to the subject. They also add weight, because of this consistency, to our observations concerning the variable access of different population groups to the best sources of information. For evidently, persons who were introduced to the topic of VD by responsible sources continue to obtain the bulk of their knowledge from similar sources, while the reverse is true with those who had presumably uncontrolled initiations into the subject.

Sources of Most Information

	Parents, School, Military, Professionals	Friends, Acquaintances and Others	Impersonal Media of All Kinds
	%	%	%
Well-Informed	46	28	39
Mod.-Informed	36	47	38
Least-Informed	18	25	23
Total Cases (No. of Responses—100%)	(130)	(98)	(128)

III. Information and Related Attitudes Toward VD and Sex

It may be assumed that, besides its variation in terms of social characteristics and mode of introduction to the topic, the level of knowledge of VD bears a varied relationship to attitudes and sentiments concerning venereal disease and related aspects of sex. Analysis of the responses from this point of view of course carries no necessary inference of causal connections, either between knowledge and the kinds of sentiments revealed or between the latter and specified behavior of any sort.

Relationship Between Information Level and Certain Other Factors
A Summary Table

		Information Level			Total Cases
		I	II	III	(=100%)
		%	%	%	
SEX:	Men	36	43	21	(119)
	Women	32	39	29	(135)
*AGE:	Young (under 35)	39	42	19	(133)
	Old (35 and over)	28	40	32	(121)
*EDUCATION:	None or Grammar	21	41	38	(56)
	High School	34	42	24	(128)
	College	43	40	17	(70)
RELATED KNOWLEDGE:	Contact) Aware	39	43	18	(102)
	Inquiry) Unaware	30	39	31	(148)
	*Kinsey) Familiar	43	42	15	(98)
	Report) Unfamiliar	28	41	31	(155)
*VETERAN STATUS:	Veteran	45	40	15	(58)
	Non-Veteran	26	46	28	(133)
SOCIO-ECONOMIC STATUS:	AB	44	37	19	(52)
	C	35	38	27	(115)
	D	27	46	27	(87)
AGE OF INTRODUCTION TO SUBJECT OF VD:	Under 15	46	38	16	(66)
	15 to 24	32	46	22	(149)
	25 and over	32	32	36	(19)
SOURCE OF INTRODUCTION TO SUBJECT OF VD:	School or parents	41	41	18	(58)
	Other personal	34	39	27	(125)
	Literature, etc.	24	43	33	(54)

The belief is widely held, with considerable support in experience and in theory, that feelings of shame, embarrassment, or guilt, arising from the association with sex and its tabus, are a major deterrent to the utilization, by many possible infected persons, of the accepted facilities for diagnosis and treatment.

Patronizing of quacks, of so-called "men's doctors", is believed to be largely attributable to the operation of such sentiments. Maintenance of anonymity while in attendance at VD clinics, and the reiterated assurance that this will be done, are regarded as minimum requirements in persuading people to come in.

A great many of the themes in VD educational literature are designed to remove or weaken the connotation of immorality, of social disapproval, in cases of venereal infection. It is of importance, therefore, to see what, if any, seems to be the relationship between the amount of information possessed by our respondents and their propensity to feelings of guilt or shame in the presence of this subject.

The questionnaire data are suggestive of the role assumed by the shame sentiment in several contexts, including: the respondent's reaction to the interview; his willingness to accept VD as a conversation topic; his freedom in alluding to sexual acts or in using sex terms; his willingness to acknowledge personal acquaintance with infected persons; and his own verbalization of the role played by shame in treatment situations. In addition, since tendencies to shame in this connection are obviously rooted in moral valuations, it will be worthwhile to examine respondents' attitudes toward socially disapproved sex behavior.[6]

Information Level and Reaction to the Interview

It would be expected that, to persons unused or unsympathetic to open discussion of these matters, a 40-minute interview on aspects of venereal disease and sex would be a source of uncomfortable tension and embarrassment. A direct appraisal of this was attempted in the use of a "tension rating" scale, in which interviewers were asked to rate respondents' tension in three degrees—great, moderate, and little or none—on the basis of broadly specified verbal, gestural, or other behavioral manifestations.

The tension ratings showed clear correlation with a number of factors: sex (men had less tension than women); age (younger persons less than older); socio-economic (increased tension with lower status);[7] and education (decreased tension with higher educational attainment). Except for education, none of these factors had a more marked association with tension than did Information Level.

Besides the tension rating, the interviewer's evaluation of respondent's cooperation and the latter's assessment of his own reaction to

---

[6] It would be well to recall, at this point, the earlier admonition against regarding these findings as other than suggestive. Cautious interpretation is especially called for in evaluating relationships, such as those to be discussed, where crucial causal directions cannot be established with any certainty.

[7] It must be added that this and subsequent findings which indicate that lower-status people have a greater tendency than higher-status people to feelings of shame in the presence of these topics are at variance with the clinical experience of some workers in the field of VD control. The issue is obviously of the highest importance, and no conclusions are safe which are not the product of more searching definition of terms and more adequate investigation of the facts.

Having Little or No Tension

		%	Total Cases (=100%)
SEX:	Men	66	(119)
	Women	56	(135)
AGE:	Young	64	(133)
	Old	58	(121)
**EDU	None or Grammar	43	(56)
CA-	High School	61	(128)
TION:	College	77	(70)
SOCIO-	AB	73	(52)
ECONOMIC	C	58	(115)
STATUS	D	56	(87)
**INFOR-	I	70	(86)
MATION	II	63	(104)
LEVEL:	III	44	(64)

the experience are indices of the same sort. The results in both of these respects are in accord with each other and with the tension ratings. The proportions of respondents on the three information levels who were rated as "Very Cooperative", or who professed to have enjoyed the interview are shown below.

Respondents' Reaction to Interview

	** Very Co-operative %	Liked Interview %	Total Cases (=100%)
Well-Informed	79	71	(86)
Mod.-Informed	52	62	(104)
Least-Informed	31	52	(64)

Information Level and Acceptance of VD as Conversation Topic

Whether or not a person is at ease in talking about venereal disease is also indicated by the extent to which it constitutes for him an acceptable topic for general discussion. While the discussant's preference may not always be the sole or principal consideration in the choice or avoidance of VD as a topic, there is a possible index of its acceptability in answers to the question: "Have you talked about VD with anyone in the last year or so?" Only among the Well-Informed had a majority of respondents had such discussions: 53% of these had talked about it compared with 41% of the Moderately-Informed and 29% of the Least-Informed. (This can, of course, sustain an opposite interpretation: that talking about VD —for whatever reason—led to increased knowledge of VD.)

Information Level and Freedom of Reference to Sexual Intercourse

The emotional content of sex terms and of allusions to sex is likely to be manifested in reluctance to employ such terms or to make such allusions, even where their use is clearly called for and the inhibiting factor is not ignorance. More in the hope of revealing this type of resistance than as a real measure of information,[8] the sample was asked: "How do people catch syphilis?" Sixty-two percent of all respondents spontaneously mentioned sexual intercourse as a medium; 20% chose to name transmission from some contaminated object, such as a toilet seat, drinking utensil, or towel.

The role of resistance becomes evident when it is found that, asked almost immediately afterward to name the *one most likely way*, the proportion citing intercourse rose to 81%—with only 6% persisting in mentioning inanimate contacts.

It is also in point that responses to this question were correlated with the tension rating: only 33% of those with great tension chose intercourse as their first mention, compared with 49% of those with moderate tension and 75% of those with little or no tension.

Differences are also in evidence in the case of different levels of information about VD. Least-Informed respondents apparently find it more difficult than do those in the better-informed categories to bring themselves to the mention of sexual intercourse, even when asked for the one most likely way of catching syphilis. Moreover, they included a larger proportion who chose to name contaminated objects: 29%, as compared with 20% of such mentions by Moderately-Informed, and 19% by Well-Informed respondents.

Proportions Naming Intercourse As the Way Syphilis Is Caught, When Asked

	** a. How Do People Catch Syphilis? %	* b. What Is the Most Likely Way? %	Total Cases (=100%)
Well-Informed	73	92	(86)
Mod.-Informed	70	86	(104)
Least-Informed	42	73	(64)

[8] We do not exclude the possibility that variations in the "sex intercourse" response (however phrased) may also reflect differences in information itself; i.e., that persons who do not cite it as a vehicle for infection may actually be ignorant of its role in this connection; but it seems unlikely that this could be true of more than a handful of these respondents.

Information Level and Acquaintance with Infected Person

Reluctance to acknowledge personal acquaintance with someone who has been infected varied with the amount of information the respondent had about venereal disease. For the sample as a whole, 56% replied "No" to the question: "Have you ever known anyone who had syphilis?"

Education and socio-economic status also exerted some influence upon the proportions acknowledging such acquaintance. Their comparative showing with Information Level is seen in the table.

Although the number of cases does not permit testing the apparently strong association with Information Level by tabulations holding other factors constant, there is, again, supporting evidence of its validity in the fact that these responses are also correlated with the tension ratings: the greater the tension, the more reluctance to admit having known someone with syphilis.

None of these interpretations, naturally, disposes of the alternative possibility that the responses *may* be based upon objectively real differences in acquaintance with infected persons.

Proportion Denying[9] Acquaintance with Infected Person

		%	Total Cases (=100%)
*SOCIO-ECONOMIC STATUS:	AB	45	(52)
	C	64	(115)
	D	49	(87)
EDUCATION:	None or Grammar	61	(56)
	High School	56	(128)
	College	49	(70)
**INFORMATION LEVEL:	I	39	(86)
	II	60	(104)
	III	72	(64)

It will be noted that the result, above, in the case of socio-economic status is unclear because of its failure to display a consistent direction from high to medium to low status. It is also suggestive that the difference between the AB and the C groups

[9] As was anticipated, military service made the greatest difference of all in acknowledgment of acquaintance with infected persons: only 21 percent of veterans, as against 51 percent of non-veteran males denied such acquaintance. Also consistent with expectation, the more casual character of the veterans' acquaintance is evident in that only 9 percent of veterans had known these people "very well," but 30 percent of non-veterans rated the acquaintance in this degree.

reverses expectation, since it might have been anticipated that respondents from the level in which VD is more prevalent—C—would acknowledge more acquaintance with infected persons. That this is not so leads to the hypothesis that willingness to admit such acquaintanceships is also affected by status-feeling: the desire to avoid identification with something that has a lower-class association.

Information Level and Moral Evaluations

It was assumed earlier that the guilt and shame feelings which we are discussing are rooted in the belief that venereal infection almost invariably implies sexual transgression. It follows that persons who do not share as intensely as others the prevailing evaluations of unsanctioned sex behavior should, on that account, be less likely to associate shame or guilt with the contraction of a venereal disease.

(The possibilities of acquiring venereal disease "innocently"—as, congenitally, or unknowingly from an infected spouse—cannot enter here as exceptions, since the imputation of wrongdoing to a parent or spouse will probably be as shameful to the infected person as if directed toward himself.)

Respondents' estimates of the extent to which people engage in non-marital sex relations were considered to be at least partially projective and, as such, clues to the degree of their adherence to moral code values. The estimates appear clearly correlated, for example, with educational attainment, the better-educated respondents giving higher estimates of both pre-marital and extra-marital sex relations.[10]

Whether the respondent is aware of the Kinsey Report (with its emphasis, in popular understanding at least, upon the wide divergence between sexual principle and practice) also makes a difference, as would be anticipated; but not to the same extent. The proportions asserting that "most" people have illicit sex experience are the same whether or not they know about the Report, but the proportion attributing such experience to "about half" of the population is larger among those who are familiar with the Report than among those who are not.

Respondents who are better informed about VD tend to have higher estimates of the extent of non-marital sex relations than

[10] Again, it is important to point out that such of the findings as indicate more shame and embarrassment among lower-status (educationally, economically) than among other people in the presence of these topics are controversial. It may well be, for example, that the differences found in this study exist principally on a verbal level; that they reflect differential capacities for being articulate on venereal subjects, and are not reliable indices of probable behavior in action situations. These considerations are more adequately explored in the Ohio and Mississippi studies, already referred to.

do those not so well informed. Although the differences are not striking, they are in accord with the picture of the better-informed as being less prone to the expression of traditionally shame-oriented responses.

Proportions Believing That Half or More of the Population Engage in Non-Marital Sex Relations

	Pre-Marital	Extra-Marital	Total Cases
	%	%	(=100%)
Well-Informed	84	49	(86)
Mod.-Informed	81	43	(104)
Least-Informed	63	24	(64)

Consistent with this, though less pointed, is the showing on the morally related question whether complete avoidance of non-marital sex relations is the only sure way to avoid catching a venereal disease. This is a thesis compounded of mutually reinforcing elements, citing hygienic interests in behalf of the moral principle of continence and, at the same time, urging the moral principle as reason for seeking the hygienic goal.

The smallest proportion of respondents agreeing to the affirmative of this proposition was found among the Well-Informed: 30%; 49% of Moderately-Informed persons and 43% of Least-Informed persons held that restricting oneself to the socially approved sex outlet was the one certain way to avoid infection.

A sharper distinction among the Information Groups, though one not so obviously related to the moral issue, resulted from comparison of responses mentioning alternative precautionary routes. Prophylaxis was mentioned by 34% of Well-Informed respondents, by 25% of the Moderately-Informed, and by only 8% of the Least-Informed.

Comparisons were less successful in the case of a question which involved attitudes toward unsanctioned behavior occurring in a more intimate context, the circle of respondent's own friends and acquaintances. Respondents were asked whether they would change their opinions of a friend who had sex relations outside of marriage; this was asked with regard, first, to an unmarried, then to a married, friend.

In both cases, there were differences in the proportions on different Information Levels who thought they would, or might, change their minds about the hypothetical erring friends, but these differences are contradictory and insignificant. If the friend is single, there is apparently a tendency for him to be judged more severely, the less the respondent is informed about VD; this reverses itself when

the friend is married, and slightly more Well-Informed than other respondents state that they would change their minds about him. No explanation is suggested for this.

IV. Conclusion

Since the announced purpose of this paper was to see what the Bloomingdale [11] survey results could tell us about the social and psychological correlates of varying amounts of information about venereal disease, it necessarily stops where the range of the interview data ends. Our review of those data which were pertinent appears to support the hypothesis that people who are well-informed, moderately-informed and least-informed about VD differ according to certain basic social characteristics.

The person who is under 35 years of age, who has completed at least high school, who is in a relatively better socio-economic position, is more likely than others to be well-informed about VD. If he is a veteran, his chances of being well-informed are even better. He is likely to have learned about venereal disease in early adolescence and to have received his information from responsible sources such as his parents or teachers, rather than from friends or from formal materials to which he has had access.

The well-informed person's attitudes toward sex and the sex-related aspects of VD are less likely to be characterized by overtones of shame and embarrassment; he speaks readily about these matters and evidences little tension when they are brought up for discussion.

The least-informed person, by contrast, is at the opposite end of the scale with respect to most of these attributes. He is a good deal more likely to be over 35 years of age and a good deal less likely to have finished high school; he will, with greater probability, have been introduced to the subject of VD by reading matter obtained in presumably undirected ways; and he is more likely to be of lower socio-economic status. He is markedly more subject to embarrassment and tension in the presence of the topics of venereal disease and sex.

We have remarked earlier that one of the implications of these differences is that the population groups which, statistically, show the greatest need for VD control are precisely the ones in which the amount and quality of information about VD is likely to be the least. Whether this is the serious matter it seems to be, depends upon the kind of relationship that is found to exist between knowledge and the forms of behavior which are considered desirable.

[11] The part of Manhattan in which the survey was made is known as the Bloomingdale district.

As was observed in the opening paragraph, this relationship—and the conditions of its operation—are of great importance to public health work with the venereal diseases, whether the paramount concern be, on the one hand, prevention, or, on the other, case-finding and treatment.

The areas covered by this study have not, by any means, exhausted the contexts in which it is important to weigh the influence of information upon individual decisions to seek diagnosis and treatment. But it seems clear enough that further appraisal will not discern a role for information as such, as an isolated entity with a force of its own. For, while it is true that, if a person is *convinced* that the facts of the case are as the VD educator presents them, he is likely to do what is wanted of him, it is equally apparent that the process thereby defined is one of *persuasion* rather than of *instruction.*

Simple presentation of the facts in an orderly fashion, we well know, is not enough to overcome resistances that are deeply rooted.[12]

So stated, the possession of information is seen to be only one in a complex of factors which are essential to getting people to avail themselves of the facilities which the community maintains for diagnosis and treatment. The complete definition of the attitudes and other factors which are relevant, and the determination of their relative importance in different situations, can merely be guessed at in studies, such as this one, which are focused upon the whole population.

They can be positively ascertained only by investigating actual clinic populations: in comparisons of those infected persons who volunteer for diagnosis with those who are required to come in, understanding of both predisposing and resistive influences can be sought with greater precision and comprehensiveness.[13]

---

[12] The literature dealing with the near-imperviousness of firmly-held attitudes and convictions to the "logic of facts" is a fairly extensive one. A great many, perhaps the bulk, of the studies bearing directly upon it are in the field of ethnic and religious prejudice. A number of these are cited and summarized in: Robin M. Williams, Jr., *The Reduction of Intergroup Tensions,* Social Science Research Council, New York, 1947, which also contains frequent references in point.

As examples from other fields may be cited: Paul F. Lazarsfeld, "The Change of Opinion During a Political Discussion," *Journal of Applied Psychology,* 23:1, February, 1939; and Robert N. McMurry, "The Problem of Resistance to Change in Industry," *Journal of Applied Psychology,* 31:6, December, 1947.

[13] The Bureau of Applied Social Research study in Columbus, Ohio, which combines community and clinic approaches, and Robert Carlson's study of Mississippi Rapid Treatment Center patients should both make important contributions to clarifications of the questions raised in this paper.

YOUTH PROTECTION

A Community Affair

by Catherine Hyde, Executive Secretary, Genesee County Christmas Seal Committee of Batavia, N. Y.

At a meeting on youth protection, held in Batavia last April under the auspices of the Genesee County Christmas Seal organization's family life committee and the Batavia Optimist Club, the sponsoring agencies and interested citizens found themselves challenged by the very logic of the situation to embark on a major undertaking in the field of their special interest, the initiation of a county-wide survey into the causes of youth delinquency and maladjustment.

The meeting was the latest in a series of events which, like milestones along a road, pointed the way to this conclusion. The first milestone was the decision, some four years back, to make a grant to a Batavia teacher to enable her to attend the summer course in family life and sex education at the University of Pennsylvania. Numerous six-week courses for parent groups have since been given by this teacher and by a second, also prepared for this work at the University of Pennsylvania.

These courses, concerned mainly with providing parents with guidance in sex instruction, have led to related projects—a one-day family life institute, with Roy E. Dickerson as speaker, which interpreted the significance of the program to the community at large;

the purchase for use of clergymen and other guidance personnel of the marriage counseling course developed by Dr. Paul Popenoe at the American Institute of Family Relations; and an extensive project in mental health education to meet needs revealed in the family life classes.

Immediate inspiration for the youth protection project came from two meetings of the preceding year. One, sponsored by the Optimist Club, emphasized juvenile delinquency in relation to recreation facilities. The other, conducted primarily for probation workers in western New York State, dealt with the rehabilitation of youthful offenders. These two meetings brought the community up sharply to face the old question: "Why isn't something done about it?" The accusing finger seemed pointed at the family life committee, if for no other reason than that it was the group well recognized for leadership in new and seemingly intangible fields.

In taking up the charge, the family life committee conceived the basic question to be: "How can we arouse the community to an awareness of its own responsibility?" The youth protection meeting was carefully planned with that thought uppermost.

Abraham Novick, assistant superintendent of the State Agricultural School at Industry, N. Y., a man of broad social and psychiatric training and much experience in working with juvenile delinquents, was invited to be the speaker. A panel of seven local persons was selected to assist with a discussion period to follow Mr. Novick's talk. The panel included Catholic and Protestant clergymen, a father, a mother, a school principal, the Children's Court judge, and a youth organization representative.

The cause? Batavia is trying to find out.

At two preliminary gatherings, the panel members explored the local scene as to types and possible causes of delinquency, and they attempted some evaluation of organizations and activities concerned with prevention and treatment. On the evening of Mr. Novick's talk effort was also made to direct audience interest towards main issues through the distribution of mimeographed copies of questions and topics which had been reviewed by the panel.

Proposes Systematic Study of Local Needs

Mr. Novick presented an excellent analysis of the many-sided nature of the youth protection problem and a thought-provoking picture of the potential contributions of community agencies. He included the suggestion that a committee be formed for the study of local needs, which study could be the basis for implementation of a helpful program. In the course of the discussion period, his suggestion bore good fruit in the passing of a motion that the panel and the family life committee serve as a nucleus to study youth needs and to organize a permanent set-up for dealing with them.

The groups thus designated accepted their responsibility in earnest, and the ensuing weeks constituted a period of intensive investigation through correspondence and interviews into suitable types of organization and methods of conducting surveys. Various panel members visited neighboring counties where youth welfare projects were already in operation. Others had conferences with the field consultant of the State Committee on Children and Public Welfare, who visited Batavia at the invitation of the family life committee.

With the completion of these preliminaries, the committee and panel met several times to report on the information collected and to discuss details of organizing and survey-making. In view of the complexities of the latter, consideration was given to enlisting expert outside assistance, and particularly to affiliating with the State Committee on Children and Public Welfare. Eventually affiliation with this group was effected, and, with the help of the field consultant, the detailed plan for conducting the survey was completed.

The survey, which covers the age years one through 18, began October 1 and will continue a full year. Agencies being covered are the Children's Court, the Probation Department, the Children's Division of Public Welfare, the State Child Guidance Clinic, the Police Department's detention facilities, and the schools and churches.

Chief fact-finding tools are record forms, generally uniform but adapted as necessary to individual agencies. These forms provide not only for the usual statistical data, but also for observations on possibly contributory home conditions such as economic factors, mental or emotional ill health in the family, lack of parental ability

to supervise children, lack of responsibility in spite of ability, and alcoholism. So that trends may be observed, comparisons will be made with routine office records for a preceding three-year period. For agencies not equipped with such records, opinion questionnaires are being used.

As this brief progress report goes to press we have passed the four-year milestone on our journey toward a youth protection program for Genesee County and have mapped out our travel plans for the year ahead. The end is not yet in sight, but we are confident that we shall stay the course and reach our destination.

This expedition into the unknown could not have been made by any of us alone, but a band of intrepid explorers such as our project has brought together is able to surmount the hazards of the long trek. Our story is, among other things, a story of cooperation. Without that cooperation we could not have come as far as we have. With it, we have made good progress toward our objective.

A CHECKLIST FOR LIBRARIANS

"Don't leave out your library!" is a frequent admonition to workers in community education and organization—and a potent source of information the library is, if it has the social hygiene materials to meet the needs of such local organizations.

From time to time the JOURNAL OF SOCIAL HYGIENE has published articles reflecting the current library picture in regard to social hygiene, notably in "The Public Library and Sex Education" (June, 1943) and in "I Want to Draw a Book On . . ." (June, 1944).

The size of a social hygiene collection, dependent as it is on the size of the library as a whole, the demand for sex education materials, and the funds at hand, is not nearly so important as its quality and its adaptiveness to various needs. This is where the resources and experience of the American Social Hygiene Association, with its library membership service, its bibliographies and its diverse publications, can be of practical assistance.

Librarians may find the following tentative checklist helpful in evaluating their social hygiene holdings. Social hygiene societies and committees may likewise find that the questions stimulate ideas for projects to work out in cooperation with librarians.

1. How many books on social hygiene are in your library?
2. Are they largely scientific or popular in their approach?

3. How many are on family ethics?

Sexual ethics?	Courtship and betrothal?
Social ethics?	Marriage?
Morals and habits?	Sex relations?
Prostitution and vice?	Human reproduction?
Birth, home and sex customs?	Celibacy and monogamy?
Family and home relations?	Syphilis and gonorrhea?

4. Which category is requested most often? Which titles?
5. How many pamphlets do you have in these same categories?
6. With the increased emphasis on adult education, have you seen a corresponding increase in the demand for materials on social hygiene?
7. In deciding which materials to buy, do you make use of two lists, Social Hygiene Bookshelf (Pub. A-453) and Social Hygiene Pamphlets (Pub. A-444), published by the American Social Hygiene Association? In helping readers to find what they want?
8. Do you consult your local social hygiene group in the selection of new social hygiene materials?
9. With what other groups do you confer when you buy new social hygiene materials?
10. Do you use selected bibliographies to stimulate the circulation of social hygiene materials among parents, physicians, health and social workers, teachers and ministers?
11. As a part of the local observance of National Social Hygiene Day, do you make a point of calling special attention in February to the library's social hygiene holdings?
12. If your library does not have them, do you order particular social hygiene books requested by your readers?
13. Are your library's social hygiene books on open shelves?
14. If not, are they on a reserved shelf? A closed shelf? In a locked case? In a restricted part of the library?
15. If they are not on open shelves, is the reason insurance against theft? Censorship?
16. Do you assist your health department by distributing free leaflets on VD?
17. Do you make recommendations on particular social hygiene films?
18. Do you use special social hygiene displays in your library?
19. Have you planned joint exhibits on social hygiene with your social hygiene society, with schools or with groups such as the PTA or ministerial association?

WHY BAN BOOKS ON PERSONAL PROBLEMS?

by Herbert D. Lamson, Professor of Sociology, Boston University

(Reprinted from the January 15, 1949 Library Journal)

As a sociologist devoting full time to college teaching and student counseling in the marriage field, I have recently been impressed with the fact that many public libraries and their staffs are not measuring up to their opportunities for service and public education. While I would be the first to send orchids to the many who are, I would like to raise a few pertinent questions.

Why should not librarians be trained in their schools of library science to handle marriage and family life (including sex) materials as professionally as medical secretaries, nurses, and physiotherapists? My students have frequently reported to me that they have had unpleasant experiences in asking for books on my basic marriage reading list. They complain that some librarians ask inquisitorial questions, give them funny looks, blush, and generally appear flustered and annoyed at such calls. Why couldn't there be in-service training for librarians in this area?

Why should not the schools which train librarians pay more attention to public relations and community organization? I know that librarians, as well as teachers, social workers, and clergymen, are under severe local scrutiny and pressure from various sources. Trustees may be living in an outmoded world. Then why should not librarians be trained to handle *trustees* and lead them into the light? Parents have odd notions. Why should there not be Parent-Library Associations as well as Parent-Teacher Associations? The librarian is also a teacher. The library is a place of education. If a library is to give its maximum service to the community, the staff has to do a real job of community organization.

Why should not libraries provide materials to answer honest questions in the fields of marriage and sex, as well as of linoleum carving and the United Nations? If the family is as central as we are told, if high divorce rates really matter, then these topics cannot be treated as just one more subject. Too many public libraries have an overly timid policy. Books in these fields are kept locked in cages and treasure rooms. One librarian explained to me that this policy arises from the fact that "books of this sort are used by perverts and the curious." One wonders whether curiosity is not a mark of every normal child.

Futile to Talk

Does not the library as well as the home, the school, and the church have a function in this area? True, sometimes books are defaced, pages

cut out. Windows are broken also. If this happens, we replace the glass, but if a book is cut or defaced, we use this as an excuse to rush everything on the subject into the safe. Schools which have instituted a program of sane sex education have reported a reduction of markings on toilet walls. One wonders whether books also would be abused less if we would have patience enough to answer all honest questions. Then this excessive emotion concerning sex materials would be lessened.

Why shouldn't libraries have suitable books on reproduction, for instance, in the children's room? Isn't it futile for adults to talk about the beauty and sanctity of marriage and parenthood if they haven't given the child some glimpses of this possibility during formative years?

Why shouldn't every library, not just a scattered few, have a family room to which high school students, parents, husbands and wives could go for answers to perplexing questions, with reference librarians trained to know this material and to feel at home in this area? Indeed, why should not the library become a family counseling center, a center of references not only to the right printed materials but also to the community resources for services of specialists in religion, medicine, psychiatry, home economics? How many troubled parents and wondering youths know of the printed resources that could help them?

Why should not local libraries work with schools, encouraging them to develop their *own* libraries to include the best materials for training boys and girls for their biggest adventure in life, marriage and parenthood? Haven't school guidance departments been too exclusively concerned with educational and vocational guidance and not enough with personal guidance? Surveys have shown that the subject of greatest reader interest in libraries is the individual himself and his personal problems. Why should not the public library be meeting a greater proportion of the demand for personal help in the family and related areas than now? Couldn't this help to cut down on some of the money people waste on quacks, as shown by Steiner in *Where Do People Take Their Troubles?*

Mottoes Belie Resources

In some communities it seems that public library policies are dictated by the narrowest, most bigoted, most fearful people in them. Why should not librarians be trained to be professional leaders, in the van rather than being forced to play the part of mere hirelings pushed here and there by some local Scrooge?

If libraries are to purchase latest novels, many of which present distorted and perverted pictures of sex and marriage, why should not they spend at least equal amounts for the other kind of material, scientific books on sex and marriage? Our communities allow all sorts of erotic stimuli to surround our youth through movies, ads, pulps, calendars, dress styles and the

like. Why should not the libraries and their staffs aid in presenting a more balanced approach?

Many community libraries have carved on their façades, sentiments in stone such as, "Dedicated to Truth and Progress" and "For the Enlightenment of All the People." Inside, the policies are often obstructive of that which is boldly proclaimed without. In many of our towns and cities, eager, curious, normal children and youth—yes and adults too—are waiting for you to turn those friezes into facts.

CARNIVAL — By Dick Turner

[Reprinted by permission of NEA Service, Inc.]

"The way I get the story, a bird left him on a flower and a bee picked him up and brought him home!"

A DECADE OF COOPERATION

A Record of Accomplishments by the Joint Committee of the American Pharmaceutical Association and the American Social Hygiene Association

by Robert P. Fischelis, Pharm. D., Executive Secretary
American Pharmaceutical Association

Ten years now having elapsed since the Joint Committee of the American Pharmaceutical Association and the American Social Hygiene Association was established, it seems appropriate not only to report on the activities of the past year but to review the accomplishments since the Committee came into being.

It will be recalled that in 1939 the American Social Hygiene Association published in the *Journal of Venereal Disease Information* a report of a nation-wide study of the practices found to exist in drugstores with relation to the disposition of applicants for advice regarding venereal diseases. This report included information collected through interviews with attendants in drugstores in 35 cities of 26 states.

The conditions revealed were not satisfactory. Tabulation of results of interviews in the 1,151 drugstores visited showed that 62 percent diagnosed the disease and offered to sell remedies for syphilis or gonorrhea, especially the latter, and 31 percent did not attempt to diagnose the case but stocked and were willing to sell bottled remedies, especially when asked for them by name. Only seven percent of the whole number refused to diagnose the disease or sell remedies.

At the invitation of the American Social Hygiene Association, Dr. Andrew G. DuMez, then president of the APhA, delivered an address before the annual meeting of the American Social Hygiene Association in Chicago in February of 1940, in the course of which he suggested that the APhA and the ASHA cooperate in an educational program to inform pharmacists regarding the venereal diseases and the means of combatting, controlling and preventing these infections. At this same meeting, Dr. Walter Clarke, executive director of the American Social Hygiene Association, suggested to the board of the ASHA that a joint committee of the APhA and the ASHA be established to accomplish the aims suggested by Dr. DuMez.

Shortly thereafter the APhA and the ASHA took the suggested action, and the Joint Committee, with Dr. DuMez as chairman, was appointed. Associated with him were two other representatives of pharmacy and three representatives of the ASHA.

A vigorous program of education was undertaken by the two associations with the cooperation of the United States Public Health Service, the state and local health departments and the state and local pharmaceutical societies. Hundreds of thousands of leaflets were distributed to pharmacists and by them to inquiring citizens. Hundreds of meetings were held, and a large number of exhibits were displayed in drugstores.

Cooperation Increased

This program, carried on year after year, made a profound change in the degree of cooperation offered by pharmacists in the matter of venereal disease control. This is best shown by a study made by the ASHA in 1945, when it was found that of 2,574 drugstores visited in 78 cities of 35 states, only eight percent offered to provide treatment for venereal disease in the absence of a physician's prescription.

In 70 percent, diagnosis and treatment were refused; in 22 percent timeworn remedies were found to be sold; and eight percent offered to provide treatment without a prescription. It should be added in relation to the second group that practically all urged the "customer" to see a doctor instead of attempting self-treatment.

In these very same drugstores, attempts were made to purchase sulfonamides. Ninety-five percent of the attendants absolutely refused to sell without a physician's prescription.

This was indeed a satisfying result of our joint efforts. There can be no doubt that the cooperation of pharmacists has contributed greatly to the decrease recently observed in the reported incidence of syphilis.

VD Totals Remain High

This cooperation should continue. Although a diminution of the incidence of syphilis has occurred, the incidence of gonorrhea shows little or no sign of decrease, and the annual number of reported cases of syphilis and gonorrhea still remains the highest of reported cases of serious communicable diseases. Thus, in the 1949 fiscal year, 639,500 cases of these two infections were reported. Furthermore, it is estimated that an equal number of cases occurred but either were not treated at all or were self-treated.

Far too large a proportion of cases of syphilis failed to seek treatment in the early stage when communicability may be quickly controlled and when the best chance of curing exists. It is still vital to the progress of venereal disease control that pharmacists continue their educational effort, directing all suspicious cases to physicians or clinics for diagnosis and treatment.

During the last year, at the request of the Joint Committee, the ASHA's field assistants visited 378 pharmacists in 62 cities of 18 states to determine the number of instances in which oral penicillin could be purchased over the counter for the treatment of a condition suggestive of gonorrhea but without a physician's prescription. It was found that of the drugstores whose attendants were interviewed, 87 percent refused to sell and 13 percent were willing to sell penicillin without a physician's prescription.

It is not necessary to remind the members of the APhA that the regulations of the United States Bureau of Food and Drugs at present require a physician's prescription as a prerequisite for dispensing penicillin in any form. The Joint Committee, at a meeting last February 21, recommended that the APhA take appropriate action on the information presented by the ASHA, and this has been done.

Observe Social Hygiene Day

Each year since the Joint Committee came into existence, the APhA and pharmacists over the nation have participated in Social Hygiene Day, sponsored annually by the ASHA. This year, with the theme "Social Hygiene Is a Family Affair," special emphasis was laid on the stimulation of interest among the students in schools of pharmacy. I am happy to report that a number of schools held meetings for the discussion of family life education and preparation for marriage and parenthood.

Kits of social hygiene publications were sent to all state and territorial pharmaceutical societies. Returns from the schools of pharmacy and from pharmaceutical societies are still coming in

so that it is not practicable at present to make a complete report of this activity.

Special mention should be made, however, of the cooperation of the New Jersey Pharmaceutical Association, which published a leaflet entitled "Social Hygiene Is a Family Affair—A Message from Your Family Pharmacist." This enterprise, sponsored jointly by the New Jersey Pharmaceutical Association, New Jersey State Department of Health and New Jersey Tuberculosis League, reached pharmacists and their customers throughout the state and created a very favorable impression.

Interests Are Broad

At the meetings of the Joint Committee, which it will be understood is advisory to both parent organizations, important and interesting subjects are regularly discussed. For example, at the above-mentioned recent meeting the much-debated question as to whether penicillin should be removed from the list of restricted pharmaceuticals was under consideration. While no final action was taken by the Committee, it is the feeling of the majority of members that a conservative policy should be followed and that for the present at least penicillin should be dispensed only on prescriptions.

This point of view is based less on considerations of the use of penicillin for the prevention and treatment of syphilis and gonorrhea than on broader scientific aspects of the subject about which much still remains to be learned through research activities. In the opinion of the Joint Committee, the widespread and entirely uncontrolled use of such a potent pharmaceutical as penicillin would result in not only inadequate self-treatment of the venereal diseases, but might complicate the clinical picture of the numerous grave conditions for which penicillin in adequate doses is most useful and perhaps produce some degree of sensitization or tolerance to penicillin which would interfere with its successful use in serious medical emergencies. The Joint Committee therefore prefers to defer action while awaiting the results of further authoritative studies now under way or to be undertaken.

Among the other subjects discussed at Joint Committee meetings are the following: legal restrictions limiting to pharmacies, physicians and certain other qualified persons and institutions the retail sale of VD prophylactics; limitation of the wholesale of prophylactic goods to those legally entitled to retail them; referral of suspected cases of venereal diseases by pharmacists to physicians and clinics; nature of information which should be provided by pharmacists to persons inquiring about conditions which may be syphilis or gonor-

rhea; cooperation of pharmacists as professionally trained citizens in efforts to repress prostitution and foster family life education. In fact, scarcely any aspect of social hygiene has been omitted from discussion in the years of the Joint Committee's work.

At a recent meeting, there occurred a discussion of the activities carried on by the ASHA for the protection of the health and moral welfare of the armed forces. The ASHA asks the help of all pharmacists and pharmaceutical societies in its appeal for Community Chest and individual financial support for this important work, help which I am sure will be forthcoming.

Endorse Services to Military

As chairman of this Joint Committee, I wish to suggest to the APhA that they go on record as strongly supporting the defense activities of the ASHA by passing,* unanimously I hope, the following resolution:

WHEREAS, protection of the health and moral welfare of the personnel of the armed forces of the United States, a majority of whom are still minors, is a responsibility of every citizen including members of the American Pharmaceutical Association, and

WHEREAS, appropriate representatives of the armed forces have asked the American Social Hygiene Association to continue its efforts to protect soldiers, sailors and airmen from commercialized prostitution and other conditions in civilian communities which endanger the health and morals of service personnel, and to provide educational materials and services to aid the armed forces in strengthening the inner defenses of young servicemen, and

WHEREAS, the American Social Hygiene Association now seeks financial support for these activities from communities and citizens throughout the nation, now, therefore, be it

RESOLVED, that the American Pharmaceutical Association strongly endorses the national defense activities of the American Social Hygiene Association and desires to see these activities continued and calls upon its members as individuals and as state and local societies to aid and support the national defense activities of the American Social Hygiene Association in all ways which may be appropriate and effective.

* The APhA's House of Delegates adopted the resolution at the 1950 convention.

BEHIND THE BY-LINES

Dr. Will H. Aufranc

Fellow of the AMA and APHA, member of the Association of Military Surgeons, Dr. Aufranc was graduated from the University of Missouri, took his M.D. at the Medical College of Virginia and his M.P.H. at Johns Hopkins. After serving as a VD control officer in Missouri, Georgia and Oregon, he entered the United States Public Health Service in 1942 as a VD consultant, and in 1948 he became assistant chief of the Division of Venereal Disease in Washington. Recently Dr. Aufranc was appointed assistant director of the Medical Division, Office of Human Resources, National Security Resources Board.

John A. Morsell

A native of Pittsburgh, Mr. Morsell was a Phi Beta Kappa graduate of the College of the City of New York, received an M.A. from Columbia and is now working toward a Ph.D. in sociology. Interested primarily in cooperative research involving social science and medicine, he worked with the New York City Department of Welfare and later directed the Institute of Community Relations of New York City's Sydenham Hospital. Mr. Morsell has worked with Columbia University's Bureau of Applied Social Research on studies of human relations in planned housing communities and on VD, and at present is working on a cooperative project with Columbia's School of Public Health preliminary to an extensive study in the epidemiology of hypertension.

For diversion, Mr. Morsell likes reading, bridge and tennis, and shares with his wife and 10-year-old son a frenzied enthusiasm for the Brooklyn Dodgers. To satisfy his interest in baseball, he will turn to any collection of boys with a ball and bat, if no major league game is at hand.

Rose K. Goldsen

Rose Kohn Goldsen, co-author with Mr. Morsell of "Who Knows What about VD?", is one of the authors of a new Harper book, *The Puerto Rican Journey: New York's Newest Migrants,* a study in assimilation.

A self-confessed dilettante at boating, chess and carpentry, Miss Goldsen doesn't merely dabble in the numerous studies that attract her inquiring mind—VD, alcoholism, cancer, the condition of Puerto Rican migrants. Sponsored in turn by Columbia University's Bureau of Applied Social Research, the Yale Graduate School and Cornell University, she has done research in Puerto Rico and has directed various studies, and now she looks forward to her Ph.D. from Yale next June, her thesis incorporating both her on-the-spot research in Puerto Rico and her investigation into the adjustment of the natives of that island in New York City.

Catherine S. Hyde

Vassar graduate and University of California graduate student, Miss Hyde taught English in New York, New Jersey and California before her appointment, six years ago, as executive secretary of the Genesee County Christmas Seal Committee of Batavia, N. Y. In her youth an ardent ice-skater, she is a drama student and amateur actress, a pianist and writer. She is now on a leave of absence to attend the University of North Carolina for a year.

Herbert D. Lamson

Professor Lamson, a Phi Beta Kappa graduate of Brown University and of Harvard, a former teacher at the Universities of Shanghai and Maine, is now sociology professor at Boston University. Teacher of marriage courses, premarital and marital counselor of students, writer of books and articles on family life, and American book review editor for the *International Journal of Sexology*, he knows whereof he speaks when he considers books, libraries and personal problems.

A native of Exeter, N. H., he is the author of *Social Pathology in China, The American Community in Shanghai, A Directory of Social Welfare Agencies in Maine*, and *Population Trends in Maine, 1870–1930*.

Robert P. Fischelis

Pharmacist and administrator, Dr. Fischelis received a Ph.G., Ph.C., and Pharm.D. from the Medico-Chirurgical College of Philadelphia, and has received honorary degrees from other colleges. Whether as professor, editor, special lecturer or chemist, as consultant to the War Production Board, as commissioned pharmacist director of the USPHS Reserve, or as chairman of the Joint Committee on Venereal Disease Control of the APhA and the ASHA, he is an authority in his field.

He is a fellow of the APHA, chairman of the general advisory board of the ASHA, consultant to the Surgeons-General of the Army and Navy, and editorial director of the *Journal of the American Pharmaceutical Association*.

He is also a collaborator of Remington's *Practice of Pharmacy* and a co-author of *Costs of Medicines* and *Principles of Pharmacy*.

BOOK NOTES

The Family Today, by Dorothy T. Dyer. Minneapolis, University of Minnesota Press, 1950. 169p. $2.50.

Prepared by Professor Dyer's graduate class in family life education at the University of Minnesota, this book will prove of value to the professional teacher of family life education through its comprehensive presentation of materials available for study and of planning techniques that may be used.

The class, unique in its composition of 15 especially selected professional workers of diverse interests and backgrounds, worked side by side with Professor Dyer in formulating five units consisting of 22 functional projects, each directed toward a heterogeneous group, a high school group in one case, a PTA group in another. The plan and content is flexible enough to admit of much interchanging of material to fit the needs of any group. The five units are: "Premarriage Considerations and Experiences;" "The Marriage;" "Pregnancy and the Birth Experience;" "The Child in the Family;" and "Social and Personal Functions of the Family."

Each of the projects under these units gives a clear definition of the objectives desired, a description of the group for which the work is intended, the number of meetings, methods and techniques, content, qualities desirable in the leader of the group, and evaluation. Lists of books, pamphlets, periodicals and films give a comprehensive picture of supplementary materials.

Extremely functional in its presentation of sample problem checklists, pretests of attitudes, suggested questions for discussion and other proposed techniques, this book will whet the appetite of professional leaders for new ideas and procedures in teaching family education.

Marriage and Family Relationships, by Robert Geib Foster. New York, Macmillan, 1950. Revised. 316p. $2.75.

This revised edition is addressed to the changed conditions and problems of the postwar era. The author, as parent, teacher and counselor, believes that in a civilization beset by family and world conflict, only the love that springs from unselfish family experience can make our personal relationships happy and our civilization better.

With the thesis that "friendliness patterns originate in the family," the author sets out to study why certain families succeed. He believes that through a study of other human beings in premarriage and family situations the student can learn to understand himself and the management of similar situations.

The arrangement of the book follows closely that of the original edition, with the subject matter arranged under four principal heads: Personal Development in

Relation to Marriage; The Immediate Prelude to Marriage; Evolving a Satisfactory Family Life; The Family and Democratic Society.

The appendix is complete with a supplementary reading-list, questions and exercises, a premarital contrast interview blank, a list of counseling and service agencies, and a list of source materials.

Having discussed with an open mind and much detail the various premarital and marital problems confronting our society, the author warns that individual and social understanding are not sufficient; we must have some knowledge of how to work out our political and economic problems as well.

Counseling Adolescents, by Shirley A. Hamrin and Blanche B. Paulson. Chicago, Science Research Associates, 1950. 371p. $3.50.

The authors, a professor of education at Northwestern University and a coordinator in the Chicago public schools' division of guidance and counseling, are well qualified to write on counseling techniques, principles and procedures in this first book of the Professional Guidance Series.

The first chapter is on human needs and adjustment. The second gets down to the problems of the adolescent, his growing maturity, need for independence, heterosexual relationships, desire for social approval, and search for a philosophy of life. Other chapters consider counseling techniques, give examples of interviews, show through case histories how various problems are solved, and present a portrait of the competent counselor.

As the authors say, the counseling process is "all of a piece," and social hygiene is one of the pieces, touched upon lightly here and there. The total effect of the book is one of synthesis, reasonable and easy to read, peppered with very human adolescent case studies—a real help to the high school counselor.

Having A Baby, by Frank Guttmacher, M.D. New York, Signet Books, 1950. 191p. 25¢.

First published in 1937 by Viking Press as "Into This Universe," then reprinted by the New American Library in 1947 as "The Story of Human Birth," this book has been brought up to date to include the latest in obstetric information.

A new first chapter, "The Accident of Birth," has been substituted for the old one and numerous deletions have been made in the old text.

As a chronology from conception to the newborn child, inspired by questions of laymen, with chapters on pregnancy, the fetus, labor, birth, operations, convalescence and complications, this little volume fills a definite popular need, especially for the expectant mother.

■

Because of the intimate nature of the human drama which is the matrix of social hygiene, few realize the scope and quality of ASHA's daily mail. To individualize social hygiene is to open a vast Pandora's box of human experience, human tragedy, human longing for health and happiness. Because the term *social hygiene* fails to connote these qualities in our work, we shall print from time to time selected letters to ASHA. We hope that you will comment, through this channel, on social hygiene matters uppermost in your mind.

■

New Jersey

Gentlemen:

Kindly write to me as I need help.

I am now keeping company with a veteran. He told me that he became infected with gonorrhea during wartime, and he claimed for the last five years he had no relapse.

I have difficulty making up my mind about marrying him.

Will you write me if there is a possibility that he is entirely cured if he has not had any relapse in the last five years? What is the duration after a cure that gonorrhea can cause a relapse? Even if no relapse has occurred, are there hidden germs causing infection to a marriage partner?

It is much more prudent if there are any doubts that I break off now than for me to have a lifetime always in fear. Kindly be frank and advise me.

What effect could gonorrhea cause to offspring? Can there be any untoward inheritance?

Gratefully,
Miss ————

Michigan

Dear Sir:

I have a boy 14 and would like some of your literature that would be very helpful for him to read. Perhaps you might have something on syphilis, etc., and sex education on whatever you have that would be helpful to him.

I should like to get them as soon as possible and if there is a charge, let me know.

Yours truly,
Mrs. ————

Alabama

Dear Sir:

I am just writing to ask a few questions.

I have been to the hospital taking treatments, and this is what I would like to know. Can a person take alcoholic drinks when he has taken penicillin shots? Will it do any harm at all?

Yours truly,
Miss ————

Florida

Dear Sirs:

My homemaking education class has read your pamphlet "Health for Girls," Pub. No. A-604, copyright, 1947. Price 10¢, Revised, 1950. They enjoyed it very much and would like an individual copy of their own. Will you please send seven copies at your earliest convenience? I am enclosing seventy cents in stamps. I will appreciate this very much.

Sincerely,
Mrs. ————

Wyoming

Dear Sirs:

I have read your article in "True Story" on venereal disease, in which they say people can be examined and treated for these diseases free.

I do not know that any of my family have or have not any symptoms of either of these diseases, but it is my opinion that every man, woman and child should be given an examination. Therefore I am asking for all the information you can give me. Where can one go in a small town, or must one go to some large city for an examination?

I am an old woman, my children and grandchildren grown, but maybe I might be able to give some one some information that would help in stopping this dreaded disease.

If it is possible, I believe there should be a law, that everyone should be examined and black out these diseases.

Please help me, and maybe I can pass on the information to someone that may be in need of help.

Yours sincerely,
Mrs. ————

South Carolina

Gentlemen:

I am teaching a high school course on family relations. This is a new course, and I would appreciate any free materials that you might have available. I thank you.

Very sincerely,
Mrs. ————

California

Dear Sir:

Please tell me. How come that when a person who has had syphilis and got treatment until well again, after a year gets it back again? How come and why? What is the best treatment now?

Mr. ————

Alabama

Gentlemen:

We are studying "Family Relations" at school. Everyone in the class is very interested in the subject and I would like for you to send us some material on this subject if you will, please.

Yours sincerely,
Miss ————

Postmarked Abroad

Hyderabad, India

Dear Friends:

It was a real pleasure to have met you at New York and I am extremely grateful to you and your organisation for the generous and friendly gestures.

At a recent meeting of the Hyderabad Social Hygiene Association, it was resolved to communicate their deep appreciation and gratefulness for the generous offer of the VD films of your association for our use in Hyderabad. We will try to make best use of the films and will keep you informed from time to time regarding our activities.

I have restarted my sex education campaign with periodical lectures, group discussions, etc., wherein the films will be of immense help and a great attraction. I hope that nothing unforeseen . . . comes in our way to carry on with the campaign. I will send a copy of our constitution by separate post.

I am extremely sorry I was not able to write to you earlier because I was occupied with the various odds and ends to restart my practice and partly I have had a pretty big mailing list of my contacts in your country. On my return to Hyderabad on the 23rd June, I was glad to see your letter enclosing the program of the annual meeting of the IUAVD at Zurich. As per promise I was able to send my paper, "The Social Aspect of VD in India," . . . in time. I would be pleased to know the reaction on the same. . . .

I hope to write to you more frequently in future and a line from you now and then will be very much appreciated.

Yours sincerely,
M. A. Hai

Copenhagen, Denmark

Dear Friends:

I wish to express my most sincere and cordial gratitude for the great hospitality I met and the invaluable help I got in the American Social Hygiene Association.

I have got an excellent impression of the immense progress in research and organization in the field of venereal diseases, and it is my hope that you will allow me in some way or other to keep a connection with the A.S.H.A. It should be of very great value for my work in Copenhagen.

I am most grateful for the kindness shown to me and the help given me from you personally and from your staff.

Sincerely yours,
Poul V. Marcussen

The Last Word

The appealing baby on the cover of ASHA's latest health education leaflet, For the Carriage Trade, is only the first of eight attractive infants pictured in the pink-and-white folder on congenital syphilis. A simple 250-word text tells an expectant mother what to do to protect herself and her baby, and why. There is room for a local agency's name and address on the last page.

Appropriate distribution channels include clinic waiting-rooms, doctors' offices, maternity hospitals, ministers, social agencies, Y's, libraries, colleges, drugstores, department-store layette counters and marriage license bureaus.

Copies are available at cost in quantity lots.

AMERICAN SOCIAL HYGIENE ASSOCIATION

Officers and Directors for 1950

President: PHILIP R. MATHER

Honorary Vice-Presidents:

CLARENCE A. DYKSTRA *
REGINALD E. GILLMOR
MAJOR GENERAL IRVING J. PHILLIPSON, USA (Ret.)
ALPHONSE M. SCHWITALLA, S.J.

Vice-Presidents:

HON. FRANCES PAYNE BOLTON, M.C.
LOUIS I. DUBLIN
CHARLES S. JOHNSON
ERNEST BOYD MacNAUGHTON

Secretary: MRS. DAVID C. PRINCE
Treasurer: ORIE R. KELLY

National Campaign Chairman: MAJOR GENERAL IRVING J. PHILLIPSON, USA (Ret.)
Chairman of the Executive Committee: BAILEY B. BURRITT
Chairman of the Finance Committee: OREL J. MYERS
Chairman of the General Advisory Board: ROBERT P. FISCHELIS

Board of Directors:
Chairman: WILLIAM F. SNOW, M.D.*

DONALD B. ARMSTRONG, M.D.
GEORGE BAEHR, M.D.
MRS. CONRAD BERENS
MRS. LOWELL BIGELOW
ROBERT H. BISHOP, JR., M.D.
MARVIN A. BLACH
BAILEY B. BURRITT
ANTON J. CARLSON, M.D.
RT. REV. MSGR. HOWARD J. CARROLL
ARMISTEAD B. CARTER
FRANK C. COMBES, M.D.
MRS. LESLIE B. CUTLER
MICHAEL DAROFF
MISS IRMA DE VOE
WILLIAM L. FLEMING, M.D.
WILLIAM S. HENSON
P. D. HOUSTON
ALAN JOHNSTONE
W. F. LORENZ, M.D.
ROSS T. McINTIRE, M.D.
OREL J. MYERS
ROBERT M. OWTHWAITE
THOMAS PARRAN, M.D.
MRS. DWIGHT S. PERRIN
LEONARD A. SCHEELE, M.D.
FRED G. SCHERER
MRS. HARPER SIBLEY
WALDO L. TREUTING, M.D.
ARNULF UELAND
MRS. J. B. WATERMAN

Executive Director: WALTER CLARKE, M.D.

* Deceased

ASHA's Job in National Defense

★ To study prostitution conditions, particularly near military installations and industrial centers

★ To prepare fully documented reports on local prostitution conditions for the information and guidance of military and civil authorities

★ To provide community leaders with the facts about the dangers of commercialized prostitution

★ To advise communities on the most effective ways of repressing vice and to recommend ways of treating sexual delinquents

★ To stimulate adequate wholesome recreation as a morale-building safeguard against sexual misconduct

★ To intensify the spread of sound information about venereal disease, particularly to young people entering the Armed Forces

★ To help strengthen family life against the tensions of the times by fighting VD and sexual promiscuity, two major threats to family health and well-being

★ To encourage education for family life, through publications, study courses for parents, and formal training for teachers, youth leaders and others who influence young people

THE AMERICAN SOCIAL HYGIENE ASSOCIATION
1790 BROADWAY • NEW YORK 19, N. Y.